STATE OF CALIFORNIA COURT
OF CLAIMS

FREDDY MCCARDIE,
Claimant,

against

The California State Prison-Corcoran

CASE #

Claimant Mccardie, appearing pro se, complaining of defendant, the California State Prison Corcoran, alleges the following:

1. The post office address of the claimant herein is P.O Box 3466, Corcoran, California 93212.

2. This claim is for negligence of California State Prison Corcoran, committed by its employee for failure of its employee Doctor J. Peare to provide adequate medical care following accepted medical standards on November 10, 2019 through June 14, 2020, and thereafter, while acting within the scope of his employment and in the discharge of his duties, on November 10, 2019 through June 14, 2020 at CSPC-3A-facility, so as to cause serious injury to the claimant Feddy Mccardie.

3. Claimant alleges as follows, On Sunday, November 10, 2019 he submitted a CDCR 7362 with request to be seen by his Primary Care Provider (PCP) to have his lower bunk lower reinstated due to pain in his left knee when walking up the stairs or jumping on to the top bunk.

4. Claimant alleges, that proof of his (ADA) is inserted on his (ADA) Effective communication Patient Summary in regards to his Durable Medical Equipment [SEE EX. A]

5. Claimant alleges, that defendants deliberate disregards, and intentional negligence to his well established medical needs, could be proven up the Face of defendants own responsdance to his Health Care Grievance # CSPC-1900127 3-HC, where defendant offered misleading statements as follows:

(A) 11/10/19 Claimant request lower and lower tier removal

(B). 11/15/19 Claimant request lower and lower tier removal

(C) But on 11/21/19 requested and noted that his mee was updated to retlect the reinstated of his Cane and mobility vest removal

(D) Also on 11/27/19 defendants finally acknowledge Klaimants request to have his lower bunk and tier reinstated due to pain in his knee when walkin up stairs. SEE EXHIBIT (A)

6. Claimant alleges, that defendants, failed to acknowledge that his durable Medical equipment (DME) were issued as Permanent, as to forever under medical standdare to fully and effectively accommodate his medical needs and disabilities. which are:

(A) Needs for:

Eyeglasses Permanent
Foot Orthoses Permanent
Knee Braces Permanent
Therapeutic shoes, Permanent
Wrist support Brace Permanent

7. Claimant alleges that as soon as he began to initiate and maintain complaints defendants he began to suffer the denial of his necessary and much needed Durable Medical Equipments.

8. Claimant alleges that it could be found upon the Face of his Grievance # CSPC-1fC. 19001273 that defendants were highly knowledgeable of his medical needs, but Chose to ignore them, by fabricating issues and information during a Department investigation, which continued up the Chain of Command

9. Defendants Stated that as December 11, 2019 through January 15, 2020, Plaintiff/claimant Continued to request for removal of his lower bunk and Tier Chrono: which was false, when this Appeal was initiated on 12/16/19,

requesting to be accommodated.

10. Defendants continues to exercise deliberate indifference to Claimants' Medical Health Care by their negligence in providing him with the appropriately ordered medical accommodation in which to adequately assist him in his daily activites, such as walking :

11. As a result of Defendants' negligence and deliberate indifference to plaintiff/ claimants' medical conditions, plaintiff/claimant continues to suffer from severe pain to his knee Claimant is a Mental Health patient, with Grade scores below (0.4). Defendants have used such disabilities Against him in his attempts of seeking resolution. (

12. The particulars of claimants' damage are as follows:

Pain and Suferring.

Permanent disability

$ 5000 00

13. Attached hereto as part of the claim is the Grievance COPC-HC-1400 1273 with supportive documents of the place and events described incidents.

14. This claim is filed within the one year requirement after the claim Accured, as required by State law.

WHEREFORE, Claimant respectfully requests judgment against defendants in the the sum of $5000.00 dollars.

Date: JUNE 21, 2020

x Freddy McCardle
Pro Se

This claim was EXECUTIVE on This 21, day of, JUNE 2020.

I declare under the penalty of perjury that the Foregoing is True and correct to the best of My Mental Disabilities And knowledge.

x freddy mccardle
Signature

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
Government Claim Form
DGS ORIM 06 (Rev. 05/2016)

Government Claims Program
Office of Risk and Insurance Management
Department of General Services
P.O. Box 989052, MS 414
West Sacramento, CA 95798-9052

1-800-955-0045 ▪ www.dgs.ca.gov/orim/Programs/GovernmentClaims.aspx

For Office Use Only

Clear Form Print Form

Is your claim complete?

- [x] Include a check or money order for $25 payable to the State of California.
- [x] Complete all sections relating to this claim and sign the form. Please print or type all information.
- [x] Attach copies of any documentation that supports your claim. Please do not submit originals.

Claimant Information *Use name of business or entity if claimant is not an individual*

1	MCCARDIE (Last name)	FREDDY (First Name)	(MI)	2	Tel:
				3	Email:
4	P.O. BOX 3466 (Mailing Address)	CORCORAN (City)		CA (State)	93212 (Zip)
5	Inmate or patient number, if applicable:				
6	Is the claimant under 18?	If Yes, please give date of birth: N/A			
7					

If you are an insurance company claiming subrogation, please provide your insured's name in section 7.

8 N/A

If your claim relates to another claim or claimant, please provide the claim number or claimant's name in section 8.

Attorney or Representative Information

9	N/A (Last name)	(First Name)	(MI)	10	Tel:
				11	Email:
12	N/A (Mailing Address)	(City)		(State)	(Zip)
13	Relationship to claimant: N/A				

Claim Information *Please add attachments as necessary*

14 Is your claim for a stale-dated warrant (uncashed check)? ○ Yes ○ No *If No, skip to Step 15.*

State agency that issued the warrant:

Dollar amount of warrant: Date of issue: MM/DD/YYYY

15 Date of Incident: November 10, 2019

Was the incident more than six months ago? ○ Yes ○ No
If YES, did you attach a separate sheet with an explanation for the late filing? ○ Yes ○ No

16 State agencies or employees against whom this claim is filed: California State Prison Corcoran, Warden Ken Clark and J. Pearce.

17 Dollar amount of claim:

If the amount is more than $10,000, indicate the type of civil case:
○ Limited civil case ($25,000 or less)
○ Non-limited civil case (over $25,000)

Explain how you calculated the amount: intentional infliction of emotional and mental anguish, severe knee pain, and incontinent-bility.

23	This section must be completed if the claim involves a motor vehicle. • Indicate whether a claim has been filed with your insurance carrier. ○ If a claim has been filed with your insurance carrier, provide the name, telephone number, and mailing address of the insurance carrier. Also include your policy number and the amount of the deductible. ○ If you have received payment, please indicate the date payment was received and the dollar amount.
24	The claimant or the claimant's attorney or representative must sign this form.
25	Be sure to attach the $25 filing fee. • Please make your check or money order payable to the State of California. • If you cannot afford the filing fee, you can fill out a "Filing Fee Waiver Request", and attach it to this form. ○ You obtain the filing fee waiver request form at www.dgs.ca.gov/orim or by calling: 1-800-955-0045.

18	Location of the incident: California State Prison Corcoran, 3A - Facility
19	Describe the specific damage or injury: ON November 19, 2019 through June 2020 Dr. B. Pearce continued to deny me reinstatement of my Durable Medical Equipment which were permanent to assist injury of my Left knee. Warden Clark concurred such refusal, without intervenence or correction of such negligence to medical care.
20	Explain the circumstances that led to the damage or injury: SEE ATTACHED COMPLAINT. "STATE OF CALIFORNIA COURT OF CLAIMS"
21	Explain why you believe the state is responsible for the damage or injury: DEFENDANTS had KNOWLEDGE of CLAIMANTS' MEDICAL DISABILITIES, But CONTINUED TO SHOW and DEMONSTRATE deliberate disregards such medical condition and Needs
22	Does the claim involve a state vehicle? ○ Yes ○ No
	If YES, provide the vehicle license number, if known:

Auto Insurance Information

23				
	Name of Insurance Carrier			
	Mailing Address	*City*	*State*	*Zip*
	Policy Number:		Tel:	
	Are you the registered owner of the vehicle?		○ Yes	○ No
	If NO, state name of owner:			
	Has a claim been filed with your insurance carrier, or will it be filed?		○ Yes	○ No
	Have you received any payment for this damage or injury?		○ Yes	○ No
	If yes, what amount did you receive?			
	Amount of deductible, if any:			
	Claimant's Drivers License Number:		Vehicle License Number:	
	Make of Vehicle:	Model:	Year:	
	Vehicle ID Number:			

Notice and Signature

24	I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true and correct to the best of my information and belief. I further understand that if I have provided information that is false, intentionally incomplete, or misleading I may be charged with a felony punishable by up to four years in state prison and/or a fine of up to $10,000 (Penal Code section 72).
	x Freddy McCardle — Signature of Claimant or Representative; Freddy McCardle — Printed Name; Date: June 28 2020
25	Mail this form and all attachments with the $25 filing fee or the "Filing Fee Waiver Request" to: Government Claims Program, P.O. Box 989052, MS 414, West Sacramento, CA 95798-9052. Forms can also be delivered to the Office of Risk and Insurance Management, 707 3rd street. 1st Floor ORIM, West Sacramento, CA 95605.

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
Government Claims Program Fee Waiver Request Packet
DGS ORIM 05 (Rev. 05/2016)

Government Claims Program
Office of Risk and Insurance Management
Department of General Services
PO Box 989052, MS 414
West Sacramento,CA 95789-9052

1-800-955-0045 ▪ www.dgs.ca.gov/orim/Programs/GovernmentClaims.aspx

Information and Instructions

Filing Fee for Government Claims Program

Beginning August 17, 2004, anyone wishing to file a government claim for money or damages against the state must pay a $25 filing fee unless the person qualifies for a fee waiver. (Gov. Code, § 905.2(b).)

To request a fee waiver, you must fill out the attached Affidavit for Waiver of Government Claims Filing Fee and Financial Information Form.

Step	***Instructions for filling out each step on the attached form. The form begins on page 3 of this packet.***
1	On the attached form, provide the full name of the person requesting the fee waiver.
2	Provide a daytime telephone number.
3	If you already have a claim number and you know what it is, write it in this space.
4	Provide complete contact information for your employer and your spouse's employer, if applicable.
5	If you are an inmate in a correctional facility, please attach a certified copy of your trust account balance, provide your Inmate Identification Number, and skip to steps 23 and 24 and complete them.
6	Complete this section if you are receiving financial assistance under Supplemental Security Income (SSI), State Supplemental Payments Programs (SSPP), CalWORKS, food stamps, county relief, general relief (GR) or general assistance (GA). If you answered **yes** in this category check all types of assistance you get, then complete step 24. You are finished. If you checked **no**, continue to step 7.
7	Find the number of people in your household and check the box **only** if your total monthly household income is less than the amount shown. For instance, if there are five people in your household and the total monthly household income is less than $2,294.79 or less check **E**. If there are more than 8 people in your household, calculate the income limit by adding $331.25 for each additional person to the income level for an eight-person household. List the number of people in your household and total household income in **I.** **If you checked any box in this step, complete steps 9 through 15 then skip to step 24.**
8	If you cannot pay for the common items needed for daily life, such as food, shelter, medical care and personal safety for you and your household members, check yes in this category. **If you check yes to this question, fill in steps 9 through 24.**

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22	Does the claim involve a state vehicle? ○ Yes ○ ~~No~~
	If YES, provide the vehicle license number, if known:

Auto Insurance Information

23				
	Name of Insurance Carrier			
	Mailing Address	*City*	*State*	*Zip*
	Policy Number:		Tel:	
	Are you the registered owner of the vehicle?		○ Yes	○ No
	If NO, state name of owner:			
	Has a claim been filed with your insurance carrier, or will it be filed?		○ Yes	○ No
	Have you received any payment for this damage or injury?		○ Yes	○ No
	If yes, what amount did you receive?			
	Amount of deductible, if any:			
	Claimant's Drivers License Number:		Vehicle License Number:	
	Make of Vehicle:	Model:	Year:	
	Vehicle ID Number:			

Notice and Signature

24	I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true and correct to the best of my information and belief. I further understand that if I have provided information that is false, intentionally incomplete, or misleading I may be charged with a felony punishable by up to four years in state prison and/or a fine of up to $10,000 (Penal Code section 72).
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PROOF OF SERVICE BY MAIL

BY PERSON IN STATE CUSTODY

(Fed. R. Civ. P. 5; 28 U.S.C. § 1746)

I, FREDDY MCCARDIE, declare:

I am over 18 years of age and a party to this action. I am a resident of CORCORAN California State Prison Corcoran, Prison,

in the county of Kings,

State of California. My prison address is: P.O.BOX 3466 (3A-4-109U)

Corcoran, CA 93212.

On June 16, 2020,
(DATE)

I served the attached: Proof of service/ Permission for Late Claim/ Government claim Complaint w/ EXHIBITS
(DESCRIBE DOCUMENT)

on the parties herein by placing true and correct copies thereof, enclosed in a sealed envelope, with postage thereon fully paid, in the United States Mail in a deposit box so provided at the above-named correctional institution in which I am presently confined. The envelope was addressed as follows:

Government Claims. Programs
OFFICE OF Risk and Insurance Management
P.O. Box 989052, MS 414
West Sacramento, CA 95798-9052

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on June 16, 2020
(DATE)

Freddie Mccardie
(DECLARANT'S SIGNATURE)